Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
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Original Public Report

Report Issue Date: November 21, 2022

Inspection Number: 2022-1054-0002

Inspection Type:
Other
Complaint
Critical Incident System

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Guildwood, Scarborough

Lead Inspector	**Inspector Digital Signature**
Eric Tang (529)	Siu F Tang 2022.11.22 14:23:01 -05'00'

Additional Inspector(s)
Amandeep Bhela (746)
Miko Hawken (724)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 26-28, 31, November 1-4, 2022

The following intake(s) were inspected:
- An intake (follow-up) related to infection prevention and control.
- Two intakes related to prevention of abuse and neglect.
- An intake related to food, nutrition, and hydration, housekeeping, laundry, and maintenance services, staffing, training, and care standards, and resident care and support services.
- Two intakes related to prevention of abuse and neglect, and staffing, training, and care standards.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order was found to be in compliance: Order #001 from inspection #2022_1054_0001 related to O. Reg. 246/22, s. 102 (8) was inspected by Eric Tang (529).

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Resident Care and Support Services
Responsive Behaviours
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (9) (b)

The licensee has failed to ensure that the resident's infectious symptoms were recorded every shift.

Rationale and Summary
The resident's electronic health records indicated that they had developed an infection. As per resident records and the infection prevention and control (IPAC) lead, the resident's infectious symptoms were not recorded on two shifts during the duration of their infection. The IPAC lead further asserted that their symptoms should have been recorded every shift during this time period.

Failure to record the resident's infectious symptoms every shift may hinder staff from monitoring the resident's response to the treatment.

Sources: Resident's electronic health records; interview with the IPAC lead. [529]

WRITTEN NOTIFICATION: Consent

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 7

The licensee has failed to obtain consent from the resident when care or services were provided.

Rationale and Summary
A complaint was received by Ministry of Long-Term Care (MLTC) alleging consent was not obtained in relation to a change in medical treatment for the resident.

The resident had appointed an individual as a decision maker upon admitting to the long-term care (LTC) facility. A medical treatment was prescribed and initiated to treat a suspected medical condition. However, the resident was then diagnosed with a different condition in which the treatment had to be altered. The change of medical treatment was not communicated to the decision maker until a later time.

Both the registered practical nurse (RPN) and the LTC consultant asserted that the resident's decision maker was to be contacted for care or service consent, and confirmed that they were not contacted for consent prior to changing the medical treatment.

There was a moderate risk and severity to the resident as their decision maker was not provided an opportunity to participate in the resident's plan of care.

Sources: Resident's health records, home's complaint binder; staff interviews with the RPN, and the LTC consultant. [529]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary
A complaint and a critical incident system (CIS) report were received by MLTC in relation to an intervention provided by the nursing staff to address the resident's responsive behavior.

As per resident records and the resident's care plan, a specific intervention was to be provided when the resident exhibited a type of responsive behavior.

A review of the home's records and multiple interviews with the nursing staff indicated that an alternate intervention was provided to the resident when they were exhibiting responsive behavior on an identified occasion. The home's LTC consultant confirmed that the specific care intervention was not provided by staff as per the resident's care plan at that time.

Sources: Resident and home records, CIS report; staff interviews with PSWs, RPN, and the LTC consultant. [724]

WRITTEN NOTIFICATION: Records

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 231 (b)

The licensee failed to ensure that the resident's written record was kept up to date at all times.

Rationale and Summary
A complaint was received by MLTC in relation to the availability of nursing staff and resident care.

A resident care record which was required to be completed by the nursing staff was found to be incomplete for an identified shift. One of the Director of Care (DOC) acknowledged that the home failed to ensure that the resident's care record was kept up to date.

Failure to ensure the resident's care record was kept up to date might have impacted staff and their ability to provide the required care to the resident.

Sources: Resident's clinical records and interview with the DOC. [746]

WRITTEN NOTIFICATION: Care and Services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 8 (1) (b)

The licensee failed to ensure that there was an organized program of personal support services to meet the assessed needs for the resident.

Rationale and Summary
A complaint was received by MLTC in relation to the availability of nursing staff and resident care.

An interview with multiple nursing staff indicated that a nursing staff was not assigned and available to the resident for an identified shift and a non-staff was contacted to assist with resident care. Both the DOCs acknowledged that the home did not follow their staffing plan and failed to ensure the resident had an assigned nursing staff.

There was potential risk posed to the resident, as a home's staff member was not assigned to the resident for duration of the identified shift.

Sources: Staff schedule, resident's clinical records, and staff interview's with the nursing staff and the DOC. [746]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s.102 (2) (b)

The licensee failed to implement the Infection Prevention and Control standard issued by the Director.

Rationale and Summary
In accordance with O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to infection prevention and control. The Infection Prevention and Control (IPAC) standard for Long-Term Care Homes as of April, 2022, provided additional requirements for IPAC programs in long-term care homes.

One of the DOC was observed to be unmasked as she was communicating with two staff in an administrative area. The IPAC lead and the DOC indicated that universal masking was required when working in the home.

As a result, there was risk of spreading infectious agents, such as, COVID-19 to residents.

Sources: Staff observations; staff interviews with the DOC #104 and IPAC lead. [746]